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1971 EVALUATION OF THE RPC PROGRAM

THIRD REPORT

Summary of Survey Findings

Prepared for the Population Commission

by the

Family Planning Evaluation Office
U. P. POPULATION INSTITUTE

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INTRODUCTION

This is the third and final report of the Family Planning Evaluation Office in connection with the evaluation of the Family Planning Program of the Responsible Parenthood Council (RPC). This evaluation is undertaken by the U. P. Population Institute (UPPI) for the Population Commission (POPCOM). The First Report summarized observations of field personnel involved in the collection of survey data.[1/] The Second Report presented data from Cavite, one of the four provinces in which the survey was conducted.[2/] The present report summarizes corresponding findings from the other three provinces as well as those from Cavite and the pooled results from all four provinces taken together.

The survey design is reported in detail in the Second Report and will not be repeated here. Similarly, the analytical procedures employed to arrive at most of the figures presented here are given in greater detail in the Second Report than in this one.

[1/] "1971 Evaluation of the RPC Program, First Report: Observations and Impressions of Field Work," Family Planning Evaluation Office, U. P. Population Institute (mimeographed, 3 December 1971).

[2/] "1971 Evaluation of the RPC Program, Second Report: Survey Data from Cavite," Family Planning Evaluation Office, U. P. Population Institute (mimeographed, 21 December 1971).

It will be noted that in general the conclusions and recommendations presented in the Second Report are supported by the findings from the other provinces. The performance of the program in Leyte appears to have been considerably poorer than in Cavite; the record for Camarines Sur and La Union is more favorable. However, even in the latter provinces most of the problems indicated by the data from Cavite and Leyte were nevertheless present, albeit of lesser magnitude.

FINDINGS RELATED TO THE ACCURACY OF RECORD-KEEPING

Number of Acceptors

A finding from Cavite consistently supported by the data from the other provinces was the high proportion of "non-acceptors" among couples reported as acceptors by the RPC field personnel. Of the interviewed cases in each province the following percentages were found to be non-acceptors:

Cavite..................	23.8%
Leyte...................	51.2
Camarines Sur...........	25.8
La Union................	34.5

The over-all proportion for all four provinces taken as a whole was 33.6 per cent. In other words, only two out of three reported acceptors who were interviewed indicated that they had used BBT.

Reasons for Non-Acceptance

In the four provinces, 352 non-acceptors were interviewed. Of these non-acceptors, 66 (18.8%) said that the motivator had never visited them.

Fifty such cases were found in Leyte, alone, where before the survey serious "padding" of acceptor information was known to have occurred. No such cases were found in La Union, but seven were found in Cavite, accounting for 10.8 per cent of non-acceptors in that province, and nine (12.9% of non-acceptors) were found in Camarines Sur. Thus, in three of the four provinces there was evidence that some motivators tended to report as acceptors couples that they knew could not have accepted.

Another 54 women (15.3% of non-acceptors interviewed in the four provinces) stated that they were visited but that they did not agree to use contraception. In some cases, the error in reporting may not have been deliberate, the motivator merely misinterpreting the intention of the couple, but the large number of instances of this sort suggests that some motivators deliberately included as acceptors couples who had not in fact agreed to try BBT. The proportion of non-acceptors who fell into this category was particularly high in Leyte and Cavite (23.6% and 21.5%, respectively, of non-acceptors in the province), but such cases were not absent in Camarines Sur (8.6%) or La Union (3.5%).

In all provinces except Leyte, most of the non-acceptors were women who agreed to use BBT (the original RPC definition of "acceptor") but had not yet done so by the time of the interview. The proportions of non-acceptors in this category were as follows:

Cavite....................	67.7%
Leyte.....................	38.2
Camarines Sur.............	78.6
Là Union..................	96.5

The proportion for all provinces taken together was 65.9 per cent.

Of the 286 non-acceptors who had been visited by the motivator, 246 gave reasons for not accepting, as follows:

Reason	Number	Per Cent
Pregnant	80	32.5
BBT hard to learn or use	54	22.0
Husband uncooperative	32	13.0
No thermometer or chart	23	9.3
Post-partum amenorrhea	20	8.1
Couple wanted another pregnancy	9	3.7
No need (too old, separated, etc.)	8	3.3
Other	20	8.1

It seems likely that most of these cases of erroneously reporting non-acceptors could have been avoided if the motivators had taken more care to determine whether or not the "acceptors" were really likely to use BBT. Half (49.9%) of the non-acceptors could not use BBT at the time of acceptance simply because they were pregnant or in a state of post-partum amenorrhea following pregnancy, or the motivator did not supply them with the necessary materials. In many other cases, the motivator could have determined at the time of the home visit that the couple either did not need or did not want to try BBT. For the remainder, a follow-up visit shortly after the couple had agreed to try BBT could have determined whether they had second thoughts or difficulty in using BBT.

Date of Acceptance

In the Second Report it was noted that most (94.2%) of the Cavite acceptors said that they agreed to start before the end of March, as the RPC records indicated, but that only 88.0 per cent actually started using BBT so soon.

The pattern was similar in other provinces:

Province	Proportion who agreed by March	Proportion who started by March
Cavite	94.2%	88.0%
Leyte	79.2	76.0
Camarines Sur	99.0	77.1
La Union	100.0	84.0
All four provinces	94.3	81.3

Characteristics of Acceptors

In all four provinces there was evidence of considerable error in the reporting of characteristics of acceptors. For instance, comparison of survey responses with reported figures for age reveals only 78 to 86 per cent consistency. Moreover, these percentages overstate the actual consistency, since they refer to five-year age groups rather than single years of age. Thus, a discrepancy such as reporting a 30 year-old woman as 34 would not be indicated as an inconsistency, since the ages 30-34 are viewed as a single category.

A similar degree of error was found for educational attainment of the wife, although the variation among provinces was more pronounced, the percentages of consistent responses ranging from 73 to 90. Again the degree of consistency is overstated, since educational attainment was divided into only four categories: none to fourth grade; fifth to seventh grade; one to four years of high school; and one or more years of college. The percentage of consistent responses is especially high for La Union, as it tends to be for the other three characteristics. There is some evidence that the interviewers in La Union were less conscientious than elsewhere (a large number of reported refusals; low proportions of unstructured, verbatim responses); if this was the case, the high degree of apparent consistency in La Union may simply reflect a tendency to copy the reported (RPC) figures rather than question the respondent.

The number of living children was relatively accurately reported, the degree of consistency ranging from 90 to 95 per cent. This is probably due to the fact that number of living children is a relatively observable characteristic, so that even if the motivator did not ask the couple how many children they had, it would be a simple matter to count them.

The number of additional children desired shows the lowest consistency of the four variables in Table 1. This is probably because the incidence of failure on the part of the motivator to ask the couple about their desires is compounded by unreliability of the couple's response. The desire for additional children is a highly subjective and abstract variable and is, therefore, more likely to elicit unstable responses. Because of this instability, some of the respondents could be expected to have said one thing to the motivator and another to the interviewer. Furthermore, the couple's response when interviewed together (presumably obtained by the motivators in at least some cases) may be different from the wife's response when interviewed alone (as in the UPPI survey). Finally, the possibility of attitude change from the time of acceptance to the time of interview should not be discounted.

Most of the inaccuracies in the reporting of clients' characteristics appear to have been caused by random error. However, the reported figures for two characteristics--age and number of additional children desired--appear to have been systematically biased. Of 123 cases of inconsistency regarding age (in all four provinces), 76 (62%) were reported to be younger

TABLE 1

PERCENTAGES OF INTERVIEWED ACCEPTORS WHOSE REPORTED CHARACTERISTICS WERE CONSISTENT WITH THEIR SURVEY RESPONSES, BY PROVINCE

Characteristics	Province				All Four
	Cavite	Leyte	Camarines Sur	La Union	
Age	84.5%	77.6%	80.1%	83.8%	82.3%
Education	76.4	72.8	81.1	89.5	80.2
Number of living children	90.3	91.2	93.5	95.1	92.5
Number of additional children desired	71.7	62.2	78.9	84.6	75.1

than they were found to be during the interview: only 47 (38%) were reported to be older. Of 170 inconsistencies with regard to number of additional children desired, 99 (58%) were reported as wanting more additional children than the survey indicated they wanted, whereas 71 (42%) were reported as wanting fewer.

The finding from Cavite that educational attainment tended to be understated by the RPC motivators was not borne out by the findings from the other provinces. The opposite tendency was found in Camarines Sur and La Union, with the effect that there was no bias for the four provinces taken as a whole.

Dropouts from the RPC Program

In the Second Report, the number of dropouts in Cavite was estimated by multiplying the estimated monthly numbers of acceptors by the corresponding proportions expected, on the basis of the survey data, to continue using BBT. Since the Second Report was written, the RPC has made available new figures which allow for improved estimates of the monthly numbers of acceptors. As a result, the figures presented here for Cavite differ slightly from those given in the Second Report.

The following numbers of dropouts, expressed both in absolute terms and as percentages of the estimated cumulative numbers of acceptors, have been estimated to have occurred by the time of the survey:

Province	Number	Per Cent
Cavite...............	1891	34.7
Leyte................	3384	44.8
Camarines Sur........	2490	19.8
La Union.............	1156	23.1

In all, 8921 (29.2% of an estimated 30,578 acceptors) are estimated to have dropped out by October.

In all provinces, these proportions are considerably higher than the proportions reported by RPC in its report for October. The estimated proportion of dropouts in Leyte (44.8%) is seven times the proportion reported by RPC (10.3%). The estimated proportions in Cavite and Camarines Sur are three times as high as the reported proportions. The estimate for La Union is nearly twice the reported proportion. These figures are summarized in Table 2. Clearly, the RPC record-keeping system seriously under-reported dropouts in all four pilot provinces.

The overstatement of acceptors and the understatement of dropouts reinforce each other in affecting the reported number of continuing users. The RPC report for October indicated a total of 45,027 continuing users in the four provinces. The corresponding estimate derived from the survey indicates that less than half of this number (21,657, or 48.1% of the reported figure) were really continuing users of BBT. The breakdown by province is shown in Table 3.

TABLE 2

ESTIMATED AND REPORTED CUMULATIVE DROPOUT RATES AS OF OCTOBER, BY PROVINCE

Province	Estimated Rate	Reported Rate	Ratio of Estimated to Reported Rates
Cavite	34.7%	10.3%	3.4%
Leyte	44.8	6.3	7.1
Camarines Sur	19.8	7.0	2.8
La Union	23.4	12.7	1.8
All provinces	29.2	8.2	3.6

TABLE 3

ESTIMATED AND REPORTED CONTINUING USERS IN OCTOBER, BY PROVINCE

Province	Estimated Number Continuing	Reported Number Continuing	Ratio of Estimated to Reported Number
Cavite	3,559	5,463	.55
Leyte	4,165	15,332	.27
Camarines Sur	10,077	16,270	.62
La Union	3,856	6,962	.55
All provinces	21,657	45,027	.48

EXPOSURE TO OTHER METHODS AND PROGRAMS

Family Planning Before RPC Acceptance

There is no evidence to support the hypothesis that the RPC program might be drawing substantial numbers of BBT acceptors from clinics, thereby affecting the family planning program unfavorably. In the four provinces only 92 acceptors (13.2%) state that they had used contraception before joining the RPC program. Only 34 said that they had used pills previously: none had used the IUD; seven had used the calendar method; 46 had used withdrawal, and five had used other methods. Thus, only 4.8 per cent of all acceptors had used a highly effective method (pills). Of the 34 who had used pills before acceptance, only 8 stopped using them in order to use BBT. (Most of the rest had stopped using them well before accepting BBT. Five had tried BBT but continued using the pills at the same time and were still using them at the time of the interview.) As a result, only one per cent of all interviewed acceptors stopped using a highly effective method in order to accept BBT. It is very likely that some of these women would have stopped using pills before long even in the absence of the RPC program. Thus, the RPC program does not appear to have been making sizeable inroads into effective contraceptive practice.

With regard more specifically to clinic attendance, the findings are similar. Although 48 (6.9%) of the interviewed acceptors said that they had attended a clinic at some time before accepting BBT, only 25 said that they had also used a method of contraception (implying that most of the others had attended a clinic for other maternal or clinic health services). Of these, only 5 (0.7%) were using a highly effective method (pills) at the time of acceptance. Four of these five were found in one province (La Union); the remaining one was found in Camarines Sur. No such cases were found in the other two provinces.

Use of Other Methods by Dropouts and Non-Acceptors

Of the 277 interviewed acceptors who had stopped using BBT, 125 were pregnant at the time of the survey. Of the remaining 152 dropouts, 30 (19.7%) were using a method of contraception at the time of the survey. Half of these were using highly effective methods: 9 were using pills; 6 were using the IUD. None of these fifteen users of highly effective method and only one of those currently using less effective methods said that she had learned about the method from the RPC motivator. Clearly, the RPC motivators did not, as a rule, actively promote any method other than BBT. Thus, the information-education objective of the RPC program appears to have been fulfilled only to the extent of promoting the practice of BBT.

However, there is evidence that the motivational aspect of the RPC program may have been somewhat effective in inspiring more couples to try other methods of family planning even if the motivator did not provide information about them. Of the 152 dropouts who were not pregnant at the time of the survey, only 14 said that they had used a method of family planning before accepting BBT. In comparison, more than twice that number were using some method at the time of the survey.

Non-acceptors, on the other hand, do not appear to have been measurably affected by the motivational efforts of the RPC workers. Of 270 interviewed non-acceptors who were not pregnant at the time of the interview, only 42 (15.6%) said that they had ever used any method of contraception. Fourteen (33.3% of these 42) had most recently used the pills, 13 had used withdrawal, eight had used calendar, four had used the IUD, and three had used other methods. Only twenty-nine (10.7% of the non-acceptors who were not pregnant) were still using a method at the time of the interview. None of them had learned about their present method from the RPC motivator.

COMPLAINTS ABOUT THE RPC PROGRAM

In the four provinces combined, 142 (20.4%) of the interviewed acceptors and 104 (29.5%) of the interviewed non-acceptors specified complaints about the program. Since some of them specified more than one complaint, the total number of complaints--157 for acceptors and 116 for non-acceptors--is somewhat higher. The frequency distributions of these complaints in the four provinces individually and both the frequency and percentage distributions for all four provinces combined are given in Table 4. It can be seen that the foremost complaints of both acceptors and non-acceptors, but especially the former, are focused more on the BBT method than on the RPC program as a whole. More than half (54.2%) of the acceptors' complaints are concerned with the difficulty of using or learning to use BBT, its lack of effectiveness, and the need for other methods. Another fourth (25.5%) of the acceptors' complaints refer to the quality of instruction, reflecting jointly the difficulty of the method and the inadequacy of the motivators as instructors. The remaining complaints (20.3%) reveal other, apparently less serious, problems with the program. For instance, some respondents felt that the geographic coverage of the program should be expanded, apparently so that the ratio of motivators to population would be increased; others complained about the lack of thermometers and charts; still others felt that the RPC workers should make more of an effort to motivate husbands.

The complaints of non-acceptors were also focused most heavily on problems

TABLE 4

DISTRIBUTION OF ACCEPTORS' AND NON-ACCEPTORS' COMPLAINTS ABOUT THE RPC PROGRAM, BY TYPE OF COMPLAINT AND PROVINCE

Complaint	Province				All Provinces	
	Cavite	Leyte	Camarines Sur	La Union	Number	Per Cent
A. Acceptors						
Need for better instructions	13	17	8	2	40	25.5
Method difficult to use	11	0	19	4	34	21.7
Method ineffective	8	7	10	3	28	17.8
Method difficult to learn	2	9	4	3	18	11.5
Need for broader coverage	8	1	0	0	9	5.7
Supply problems	0	3	3	0	6	3.8
Need for more RPC methods	1	1	3	0	5	3.2
Need for involving husbands more	0	1	2	0	3	1.9
Others	0	2	9	2	13	8.9
Total	43	42	58	14	157	100.0
B. Non-Acceptors						
Method difficult to use	6	5	20	1	32	27.6
Need for better instructions	0	18	5	2	25	21.6
Listing of non-acceptors as acceptors	0	12	1	0	13	11.2
Method ineffective	2	4	5	0	11	9.5
Method difficult to learn	3	5	1	1	10	8.6
Supply problems	0	4	2	0	6	5.2
Need for broader coverage	1	3	1	0	5	4.3
Need for more RPC methods	0	1	1	0	2	1.7
Not taught	0	2	0	0	2	1.7
Others	0	5	4	1	10	8.6
Total	12	59	40	5	116	100.0

with BBT (47.4%) and instruction (21.6%), but not so heavily as those of acceptors. A larger proportion of non-acceptors (31.0%) complained of other things, principally the listing of non-acceptors as acceptors, supply problems, and the need for broader geographic coverage.

Both the acceptors' and non-acceptors' distributions of complaints varied widely from one province to another. Some of this variation is probably due to differences in the various provincial programs, but some is undoubtedly due as well to differences in the quality of interviewing and to biases caused by differences in the languages in which the interviews were conducted. It is recommended that the detailed figures in Table 4 be viewed as only approximately indicative of the magnitudes of the problems specified. Nevertheless, it is possible to conclude without hesitation that the difficulties associated with teaching and using BBT effectively are the most serious problems of the RPC program from the standpoint of its clients.

COMPARISON OF RPC ACCEPTORS AND ACCEPTORS AT CLINICS

Characteristics of Acceptors

Table 5 summarizes the percentage distributions of interviewed RPC acceptors, clinic acceptors as a whole, and those clinic acceptors who accepted rhythm, by those variables for which comparative information is available. The data on RPC acceptors are based on the survey responses of the acceptors in all four provinces combined. The data on clinic acceptors are drawn from a ten per cent sample of clinic records for the period January-March 1971.

It can be seen that the RPC acceptors tended to be older than the clinic acceptors, but similar in age to rhythm acceptors at clinics.

TABLE 5

PERCENTAGE DISTRIBUTIONS OF INTERVIEWED RPC ACCEPTORS, CLINIC ACCEPTORS (ALL METHODS), AND RHYTHM ACCEPTORS AT CLINICS, JANUARY-MARCH 1971[a]

Characteristic (1)	RPC Acceptors (2)	Clinic Acceptors (3)	Rhythm Acceptors at Clinics (4)
a. Age			
Less than 25	17.2	22.0	18.7
25-29	25.4	26.0	22.2
30-34	25.9	26.0	24.3
35-39	20.3	18.1	21.3
40 or more	11.2	7.9	13.5
b. Education			
Grades 0-4	17.8	17.1	15.4
Grades 5-7	46.8	38.5	36.0
H. S. 1-4	23.8	28.4	26.4
College	11.6	16.0	22.2
c. Number of living children			
0-2	22.4	24.2	30.1
3-4	34.6	32.5	28.8
5-6	25.8	23.7	21.1
7+	17.2	19.6	20.0
d. Number of additional children desired			
None	61.2	73.5	69.5
One	23.2	13.8	16.5
Two or more	15.6	12.7	14.0
e. Open birth interval (months)			
0-3	15.1	21.7	12.9
4-6	14.3	15.3	13.1
7-9	12.9	12.0	10.4
10-12	9.8	10.3	9.9
13-18	15.7	14.7	15.9
19+	32.2	26.0	37.9
f. Previous method			
None	86.8	74.7	66.4
Rhythm	1.0	5.8	21.1
Pills	4.9	9.9	2.9
IUD		3.3	0.3
Other	7.3	6.3	9.3
g. Previous clinic			
Yes	6.9	9.0	7.4
No	93.1	91.0	92.6

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[a] Based on 697 interviewed RPC acceptors and 8,370 clinic acceptors, but excluding cases with missing information from the percentage base. Such cases range from 0.0 to 2.0 per cent of the RPC sample and 0.5 to 5.9 per cent of the clinic sample.

With regard to educational attainment, the RPC acceptors were considerably less likely than either the clinic acceptors as a whole or acceptors of rhythm at clinics to have reached high school or college. This finding reflects the rural setting in which the RPC acceptors live. In contrast to RPC acceptors, rhythm acceptors at clinics were more likely than other clinic acceptors to have attended college. RPC acceptors are disproportionately likely to have had an intermediate education, suggesting that they are among the better-educated in relation to their (rural) neighbors, who are more likely to have completed only fourth grade or less.

RPC acceptors were not significantly different from clinic acceptors with regard to number of living children, but they tended to be less likely than the rhythm acceptors at clinics to have very few. Despite the fact that the RPC acceptors already had more children than rhythm acceptors at clinics they were also more likely to desire at least one more child. Although 69.5 per cent of rhythm acceptors at clinics said that they did not want more children, only 61.2 per cent of RPC acceptors said the same. Acceptors of methods other than rhythm were less likely than either group of rhythm acceptors to want additional children; 73.5 per cent said that they wanted no more.

The open birth interval (period of time since the last live birth) at the time of acceptance tended to be considerably longer for RPC acceptors than for clinic acceptors as a whole. However, this difference appears to be caused by the nature of the method, which cannot be used effectively until after the resumption of menstruation following pregnancy. The open birth interval of RPC acceptors was in fact, somewhat shorter on the average than that of the clinic rhythm acceptors.

RPC acceptors were much less likely than either clinic acceptors in general or clinic rhythm acceptors to have used a method of contraception before acceptance. They were more likely than the clinic rhythm acceptors to have used a highly effective method (4.9% vs. 3.2%), but the difference was not great. Similarly, RPC acceptors were slightly less likely than clinic acceptors or even clinic rhythm acceptors to have attended. a clinic before acceptance.

The above findings indicate that the RPC program is not recruiting acceptors who are much different in composition from those recruited by clinics (especially to accept rhythm) except in the following ways: RPC women are especially unlikely to be well-educated, to want to stop having children, and to have tried family planning before. Future efforts of the RPC motivators should be directed more at attracting women with less than intermediate education, and motivational appeals should place more emphasis on the advantages of family limitation as opposed to spacing.

Continuation and Pregnancy Rates

Table 6 summarizes the six-month continuation and pregnancy rates for the RPC acceptors for the four pilot provinces, individually and combined. It can be seen that the continuation rates are highest for La Union and Camarines Sur, lower for Cavite and lowest for Leyte. Conversely, pregnancy rates are lowest for La Union and increasingly higher for Camarines Sur, Cavite, and Leyte.

The continuation rates for La Union and Camarines Sur are comparable to the rates estimated for the clinic acceptors. The "first-method continuation rate" (the proportion of acceptors who can be expected to be using the first method accepted at the end of six months after the date of acceptance)

TABLE 6

SIX-MONTH CUMULATIVE CONTINUATION AND PREGNANCY RATES OF INTERVIEWED RPC ACCEPTORS, BY PROVINCE

Province	Type of Rate		
	First-Method Continuation Rate	All-Method Continuation Rate	Pregnancy Rate
Cavite	.551	.623	.204
Leyte	.456	.484	.213
Camarines Sur	.714	.735	.190
La Union	.739	.775	.152
All provinces[a/]	.625	.660	.192

[a/] Weighted averages, using the proportion of RPC acceptors in each province as weights.

is actually slightly higher for the RPC acceptors in these provinces than for clinic acceptors. On the basis of limited survey data from four clinics and the distribution of clinic acceptors by method, it is estimated that the first-method continuation rate for clinic acceptors is about .69, as opposed to .71 and .74, respectively, for Camarines Sur and La Union. However, the rates for Cavite (.55) and Leyte (.45) are considerably lower, with the result that the overall average for the four provinces (weighted by the proportion of acceptors in each province) is only .63.

The "all-method continuation rate" (the proportion of acceptors who can be expected to be using _any_ method at the end of six months after the date of acceptance) is not as high for RPC acceptors in any province as it is estimated to be for clinic acceptors. The estimate for clinic acceptors is .79, whereas the highest proportions for RPC acceptors are .78 and .74 (for La Union and Camarines Sur, respectively). Because of the especially low figures for Cavite and Leyte (.62 and .48, respectively), the weighted average for all provinces is only .66. The difference between the all-method continuation rates for clinic and RPC acceptors (.13) is greater than the difference between the first-method continuation rates (.06), because clinic acceptors who stop using their first method are more likely to try another method; RPC acceptors are more likely than clinic acceptors to stop using contraception altogether if they drop out of the RPC program (although, as noted earlier, they are slightly more likely to try another method than if they had not accepted at all). This difference reflects the lack of alternative methods in the RPC program (as opposed to the "cafeteria" approach of most clinics).

The pregnancy rate (the proportion of acceptors who become pregnant within six months after the date of acceptance) is considerably lower for clinic acceptors (estimated at .11) than for the RPC acceptors in even the most successful province (La Union, with a pregnancy rate of .15). In the other three provinces the RPC pregnancy rate is nearly twice that of the clinics. The reason for such a large difference is that the relatively low continuation rates of the RPC program are combined with a high rate of accidental pregnancy among BBT users.

Of 277 interviewed dropouts from the RPC program (in all four pilot provinces), 104 (37.5%) stopped because they had become accidentally pregnant while using BBT. Among pill or IUD acceptors, only about five per cent or less of dropouts give accidental pregnancy as the reason. The other most common causes for dropout among RPC clients in the four pilot provinces were difficulty with the method (20.6%) and loss or damage to the thermometer or chart (14.8%). The remaining dropouts (27.1%) cited a variety of other reasons, especially the absence of any need for further protection (7.6%), desire for another pregnancy (6.1%), and uncooperative behavior on the part of the husband (4.0%).

Cost-Effectiveness

The cost per acceptor for the RPC program (₱56.87) appears to be similar to that of the clinic programs taken as a whole (₱60.65). The two figures are computed in different ways, making comparison difficult, but indicate costs of approximately the same order of magnitude. The numerator of the RPC figure is the projected number of acceptors during the 15 months or so that the program is expected to be in operation (including phase-in and phase-out). It is obtained by multiplying the estimated cumulative number of acceptors at the end of October by 4/3, under the assumption that approximately 75 per cent of the total acceptors had accepted by that time. The denominator consists of the total projected expenses in the four pilot provinces, including the cost of training and other preparations prior to the start of field work. The cost per acceptor for the clinics refers to both the number of acceptors and expenditures for a single 12-month period. It is believed that the resulting figure is roughly equivalent to the cost per acceptor computed for the RPC program.

Although the cost per RPC acceptor is similar to the cost per clinic acceptor, it cannot be concluded that the RPC program functions as efficiently in terms of the ultimate objective of reducing fertility as the clinic programs, since the cost per acceptor does not take into account the effectiveness of contraception. If clinic acceptors receive better protection from pregnancy than RPC acceptors, then the costs of the two programs should be adjusted to reflect this difference. One way to measure contraceptive effectiveness is to measure the expected duration of contraceptive protection among acceptors. On the basis of the all-method continuation rates discussed above, one clinic acceptor can be expected to be protected for an average of about two years after acceptance, whereas one RPC acceptor is likely to be protected for only about 14 months on the average. The protection of one couple for one year is known as a couple-year of protection (CYP). The cost per acceptor may be adjusted to take account of the duration of protection by dividing it by the number of couple-years of protection per acceptor to yield the cost per CYP. The resulting figure for RPC acceptors is ₱49.03; the cost per CYP among clinic acceptors is only ₱29.73. Thus, in terms of the expected amount of protection provided by accepting, the RPC program is approximately 65 per cent more expensive than clinic programs in the Philippines.

The above figures are summarized in Table 7 along with the figures for each province individually. (It should be noted that the figures for Cavite in Table 7 are different from the figures given in the Second Report. This is because the estimate of expenditures provided by RPC was revised after the Second Report had been issued.) It can be seen that the RPC program operated most efficiently in Camarines Sur, at a cost of only ₱32.86 per couple-year of protection. This figure is only 11 per cent higher than the estimated cost per CYP for clinic programs. If the RPC could operate in all provinces as effectively as it has in Camarines Sur, then it would be competitive with clinic-based programs in terms of cost. At the other extreme, RPC's cost per CYP in Leyte was more than three times as high as in Camarines Sur.

TABLE 7

PROJECTED EXPENDITURES AND COST-EFFECTIVENESS OF THE RPC PROGRAM, BY PROVINCE, AND COMPARATIVE ESTIMATES FOR CLINIC PROGRAM

	Province				Total	Clinic Program (1971)
	Cavite	Leyte	Camarines Sur	La Union		
Projected expenditures (7/70-6/72)[a]	₱404,000	₱654,000	₱870,000	₱416,000	₱2,344,000	[b]
Projected number of acceptors (1/71-6/72)	7,324	10,452	16,756	6,683	41,215	[b]
Cost per acceptor	₱55.16	₱62.57	₱51.92	₱62.25	₱56.87	₱60.65[c]
Number of CYP per acceptor	1.01	.632	1.58	1.61	1.16	2.04
Cost per CYP[d]	₱54.61	₱99.00	₱32.86	₱38.66	₱49.03	₱29.73

[a] Data provided by RPC.

[b] Clinic cost per acceptor is based on data for the period July 1970 to June 1971. Expenditures by organizations operating clinics during this period were ₱16,081,250.15, and the number of new acceptors was 265,164.

[c] Data provided by Dr. Trinidad Osteria, UPPI.

[d] Cost per acceptor ÷ number of CYP per acceptor.

CONCLUSIONS AND RECOMMENDATIONS

In general, the findings reported for Cavite in the Second Report have been borne out to varying degrees in the other provinces. For the most part, the findings from Leyte are much less favorable, while the findings from Camarines Sur and La Union are more favorable. The net effect is that the overall findings for all four pilot provinces are close to those reported for Cavite. Rather than reiterate the conclusions and recommendations enumerated at the end of the Second Report, the present section will attempt to single out the most important findings and recommendations from the four provinces as a whole. Six findings stand out as most important:

1. In all provinces an extremely large proportion of reported "acceptors" had not tried to use BBT by the time of the interview, which was at least six months after the indicated acceptance date. Only 40 per cent of the misreported cases could be attributed to problems of definition (the original RPC definition of "acceptor" permitting enrollment of pregnant and amenorrheic women); most of the rest could have been avoided with more care on the part of the motivator.
2. In all provinces, the number of reported dropouts was much lower than the number indicated by the survey data.
3. In all provinces, the six-month all-method continuation rates for RPC acceptors were below the corresponding rate estimated for clinic acceptors, and the RPC pregnancy rates were considerably higher than the corresponding rate among clinic acceptors.
4. RPC dropouts were not being referred by the RPC motivators. to other methods or clinics.

5. In all provinces the RPC cost per CYP was higher than that estimated for clinic programs in the Philippines. However, the cost per CYP among RPC acceptors in Camarines Sur was close to the clinic estimate.
6. Complaints about the RPC program tended to focus on the difficulty of learning how to use BBT and the difficulty of using it effectively.

On the basis of these problems, the following three recommendations are most strongly proposed:

1. Closer supervision of motivators (including effective sanctions for poor performance) with special emphasis on ensuring the following:
    a. More accurate and complete reporting of new acceptors and their characteristics.
    b. More complete reporting of dropouts.
    c. Regular follow-up visits.
2. Improvement of training procedures to enable motivators to provide more accurate and effective instruction in the field.
3. Provision for alternative RPC methods for those who cannot or will not use BBT. In light of the simplicity and popularity of calendar rhythm, this method would appear to be a prime candidate. Provision of alternative methods should increase acceptance rates and all-method continuation rates.
4. More efforts to encourage motivators to promote non-RPC methods and, if possible, clinic attendance, especially among non-acceptors and dropouts.

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